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Department for Medicaid Services
Community Mental Health Center Services Manual
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DEPARTMENT FOR MEDICAID SERVICES
COMMUNITY MENTAL HEALTH CENTER SERVICES MANUAL

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Long Term Care and Community Alternatives
275 East Main Street 6W-B
Frankfort, KY 40621

January 2008 (Revision)

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

COMMUNITY MENTAL HEALTH CENTER SERVICES MANUAL

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I. INTRODUCTION

A. Introduction

The Kentucky Medicaid Program Community Mental Health Center (CMHC) Manual is formulated to provide you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid program. The manual is designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will assist you in understanding what procedures are reimbursable, and enable you to have your claims processed with a minimum of time involved in processing rejections and making inquires. It is arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Cabinet for Health and Family Services, Department for Medicaid Services, Office of the Commissioner, 275 East Main Street, Mailstop 6W-A, Frankfort, Kentucky 40621, or phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Cabinet for Health and Family Services, Department for Medicaid Services, Division of Long Term Care and Community Alternatives, 275 East Main Street, Mailstop 6W-B, Frankfort, Kentucky 40621, or phone (502) 564-5560. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P. O. Box 2100 Frankfort, Kentucky 40602, or phone (800) 807-1232 or (502) 209-3000.

B. Fiscal Agent

The Department for Medicaid Services contracts with Electronic Data Systems (EDS) to serve as the fiscal agent for the operation of the Kentucky Medicaid Management Information System

(MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

II. KENTUCKY MEDICAID PROGRAM

A. General Information

The Kentucky Medicaid Program is administered by the Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS). The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services rendered to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that DMS is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Department shall not reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medicaid Program, Title XIX, is not to be confused with Medicare. Medicare is a Federal provision, identified as Title XVIII, basically serving persons 65 years of age and older and qualified disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual.

B. Administrative Structure

DMS within the Cabinet for Health and Family Services (CHFS), bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. DMS makes the actual payments to the providers of medical services, who have submitted claims to the fiscal agent

(EDS) for services within the scope of covered benefits which have been rendered to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Community Based Services, Family Support Offices, located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program is guided in policy making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the council is composed of eighteen (18) recipients, including the Secretary of the Cabinet for Health and Family Services, who serves as an ex officio recipient. The remaining seventeen (17) recipients are appointed by the Governor to four-year terms. Ten (10) recipients represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) recipients are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five (5) or six (6) recipient technical advisory committee for certain provider groups and recipients. Recipientship on the technical advisory committees is decided by the professional organization the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulate that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medicaid Program has secondary liability. Accordingly, the provider of service shall seek reimbursement for the third party groups for medical services rendered. If you, as the provider, should receive payment from Medicaid before knowing of the third party's liability, a refund of that payment amount shall be made to Medicaid as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap or age.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his medical care.

When the Department makes payment for a covered service and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for

the same service accepted from the recipient. The provider may bill the recipient for services **not** covered by Kentucky Medicaid; **however**, the provider must make the recipient aware of the non-covered services **prior** to rendering them.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and /or imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky. All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

All services are reviewed for recipients and provider abuse. Willful abuse by the provider may result in his suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he receives.

When a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to Medicaid and no bill for the same service shall be paid by Medicaid.

E. Public Law 92-603

Section 1909 (a) Whoever

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under State Plan approved under this title,
(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.
(3) Having knowledge of the occurrence of any event affecting (A) his initial or continued right

to any such benefit or payment, or (B) the initial or continued right to any such benefit or

(4) payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity that is due or when no such benefit or payment is authorized, or

(5) Having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, shall (a) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more that $25,000 or imprisoned for not more than five (5) years or both, or (b) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one (1) year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State Plan approved under this title is convicted of any offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one (1) year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of an individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in case or in kind-,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five (5) years, or both.

(2) whoever knowingly and willfully offers or pays any enumeration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in-kind to any person to induce such person

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof shall be fined not more that $25,000 or imprisoned for not more than five (5) years, or both.

(3) Paragraphs (1) and (2) shall not apply to

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges

made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, nursing facility, or home heath agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more that $25,000 or imprisoned for not more than five (5) years, or both,

(d) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State Plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)

(A) as a precondition of admitting a patient to a hospital, nursing facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State Plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five (5) years, or both.

III. CONDITIONS OF PARTICIPATION

A. Provider

As defined in 902 KAR 20:091 "A Community Mental Health Center (CMHC) shall be a facility which will provide a comprehensive range of accessible, coordinated mental health services including direct patient services and indirect mental health services to the patients of a designated area."

In order to be eligible to participate in the Medicaid Program, a Kentucky community mental health center shall be licensed by the Kentucky Certificate of Need and Licensure Board in accordance with the requirements set forth at 902 KAR 20:091.

Out-of-state providers shall be appropriately licensed to provide community mental health services by the state in which they are located, participate with their State's Title XIX Medicaid Program, and shall meet the Medicaid Program conditions of participation.

B. Services

Of the services required for CMHC licensure, the following are reimbursable by Medicaid:

1. Therapeutic Rehabilitation
2. In-Patient Care
3. Outpatient Services
4. Emergency Services
5. Personal Care Home Services
6. Intensive In-Home Services
7. Collateral Services

C. Minimum Staff

Minimum staff requirements for licensure and for Medicaid community mental health center participation are:

(1) Center Director: The licensee shall designate an executive director, qualified by training and experience, which shall be responsible for the total program of the center and its affiliates in accordance with the center's written policies and for evaluation of the program as it relates to the clients' needs.

(2) Psychiatrist: A board certified or board eligible psychiatrist who may be the clinical director and directly supervises and coordinates all planning functions in the continual development and improvement of the several service elements and provides psychiatric service as indicated in all patient diagnosis and treatment.

(3) Licensed Clinical Psychologist: A psychologist licensed in accordance with the requirements set forth in KRS 319, shall provide evaluation and screening services for patients as well as individual and group therapy. This staff recipient may be utilized to lead diagnostic conferences upon assignment by the center director. The licensed psychologist may provide supervision of certified psychologist(s).

(4) Psychiatric Registered Nurse: A psychiatric registered nurse is defined by Medicaid as a registered nurse, licensed in the State of Kentucky with one of the following combinations of education and experience:

(a) Master of Science in Nursing (MSN) with specialty in psychiatric or mental health nursing. No experience.
(b) Four-year (4) educational program, with a Bachelor of Science in Nursing (BSN) and a minimum of one (1) year of experience in a mental health setting.
(c) Three-year (3) educational program Diploma graduate with two (2) years of experience in a mental health setting.
(d) Two-year (2) educational program Associate Degree in Nursing (AND) with three (3) years of experience in a mental health setting.
(e) Effective July 1, 1989, any level of education with American Nursing Association (ANA) certification as a psychiatric and mental health nurse.
(f) Any registered nurse employed by a participating mental health center in Kentucky on June 30, 1981 shall be considered a psychiatric nurse if their employment with the center continues, for the purpose of providing Medicaid Program reimbursable services.

The psychiatric nurse shall plan and supervise nursing services for psychiatric client care, and coordinate and supervises services rendered by nursing personnel with those rendered by other team administration, other departments, and medical staff in formulating policies for psychiatric patient care.

(5) Psychiatric Social Worker: The psychiatric social worker shall have an MSW degree from an accredited school of social work. The social worker shall develop complete and accurate case histories, assist patient and family in making mental and emotional adjustment to illness, engage in research and teaching activities, mobilize community resources on behalf of patients, and assist in planning for alternate methods of care.

(6) Medical Records Librarian: a medical records librarian, or capable person to perform the duties of a medical records librarian, shall be responsible for ongoing positive controls, for continuity of client care and the client traffic flow; assure that records are maintained, completed and preserved, and that required indexes and registers are maintained and statistical reports prepared; shall be responsible for seeing that information on clients is immediately retrievable, for the establishment of a central records index, and for all elements of service to provide a constant check on continuity of care. In the event that the designated individual is not a qualified medical records librarian, consultation and technical guidance shall be readily available from a person skilled in health record systems.

(7) Program Director: The program director shall be a mental health professional who shall be a psychiatrist, psychologist, psychiatric nurse, licensed professional clinical counselor, licensed marriage and family therapist or a qualified social worker. The program director may also be the executive director.

D. Additional Staff

Additional staff, as defined in Section IV of this manual, whose services may be reimbursable by Medicaid, are:

(1) Professional Equivalent: A professional equivalent is defined as an individual who by virtue of a combination of education and experience in the Mental Health field is deemed qualified by the Agency and the Professional Equivalency Review Committee of the Department for Medicaid Services to provide mental health services. The general combination of education and experience is as follows:

a. Bachelor's degree, identical field, three (3) years full-time equivalent supervised experience;
b. Master's degree, identical field, six (6) months full-time equivalent supervised experience;
c. Doctorate degree, identical field.

Identical fields shall be defined as psychology, sociology, social work and human services as determined by the Professional Equivalency Review Committee. A master's or doctoral degree program that provides a pastoral counseling component may be eligible for consideration.

The CMHC may recommend an employee for professional equivalency, but final determination of professional equivalency status is determined by Medicaid.

Please see Appendix I for the application process for professional equivalency.

(2) Mental Health Associate: The mental health associate (MHA) is an individual with a minimum of a bachelor's degree in psychology, sociology, social work, or human services as determined by the Medicaid Program as a mental health field. Only outpatient services provided by the MHA are reimbursable by Medicaid. All outpatient services notes written by the MHA shall be co-signed and there shall be a minimum of a supervisory note once a month. The mental health associate may not provide services to a mentally retarded patient.

(3) Certified Psychologist or Psychological Associate: The certified psychologist or psychological associate may be employed by the center to provide covered services under the periodic direct supervision of the licensed psychologist in accordance with KRS 319.

(4) Physician: A physician, licensed by the Kentucky Medical Board, may be employed by the Center under the supervision of the psychiatrist to render physical examinations, chemotherapy, emergency and personal care home treatment to clients of the center.

(5) Licensed Marriage and Family Therapist: The licensed marriage and family therapist may be employed by the center to provide covered services in accordance with KRS 335.300(2).

(6) Licensed Professional Clinical Counselor: The licensed professional clinical counselor may be employed by the center to provide covered services in accordance with KRS 335.500(3).

(7) Licensed Professional Counselor Associate: The licensed professional counselor associate may be employed by the center to provide covered services under the periodic direct supervision of the licensed professional clinical counselor in accordance with KRS 335.500(4).

(8) Advanced Registered Nurse Practitioner: The advanced registered nurse practitioner may be employed by the center to provide covered services in accordance with KRS 314.011(8).

(9) Psychiatric Resident Physician: The psychiatric resident physician may be employed by the center to provide covered services in accordance with KRS 311.571 and provided the resident is a medical resident as defined in 907 KAR 3:005, Section 1.

(10) Licensed Clinical Social Worker: The licensed clinical social worker may be employed by the center to

provide covered services in accordance with KRS 335.100(1).

(5) Affiliation Agreements

If a center has agreements with other agencies of organizations to provide covered services, these agreements or contracts shall be written and shall include the following:

1. A statement specifying that the resource providing services is in compliance with all existing federal, state, and local laws and regulations governing it.
2. A statement of compliance with the Kentucky Civil Rights Act of 1977, and with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90, which is as follows:

   "No person in the United States shall, on the ground of race, color, national origin, sex, handicap or age be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

3. A statement indicating reasonable assurance that medical services shall be provided by the health resource, when the service is deemed necessary by the clients attending physician.

4. A statement indicating that at the time of transfer, or, in case of emergency, as promptly as possible after the transfer an abstract or copies of pertinent clinical and other information necessary to continue the client's treatment without interruption shall be sent to the facility to which the client transfers. The information shall include the following: current medical, mental status and physical findings; diagnosis; brief summary of the course of treatment followed, pertinent social and psychological information; nursing, medication and dietary information useful in the care of the patient; rehabilitation potential, and pertinent

information concerning achievements in rehabilitation.

5. A statement indicating that clients may be transferred from one element of service to another without delay when appropriate for their treatment.

6. A statement indicating that the staff treating a client may continue to provide appropriate services during care in other elements of service, when indicated.

7. A statement indicating the basis of reimbursement between the health resource and the center.

8. A statement indicating the conditions by which the agreement may be terminated by either party.

9. Signatures by individuals authorized to execute the agreements on behalf of the resources involved.

10. In addition to the above stated criterion, each agreement with an affiliate shall comply with Section 215, Cost Related to Subcontractors and/ or Affiliate Agreements of the Cabinet for Health and Family Services Community Mental Health – Mental Retardation Reimbursement Manual.

(6) Medical Records

Medical records stress the psychiatric components of the record including history of findings and treatment rendered for the psychiatric condition and shall be evidence of the direct services rendered to individuals by the CMHC. A health record shall be maintained for each individual with all entries kept current, dated, entitled according to the service received and signed by the staff recipients rendering services. Its purpose is to serve as a basis for planning treatment and training for those being served and to provide a means of communicating between all recipients of the center and its affiliated facilities.

The records and any other information regarding payments claimed shall be maintained in an organized central file and

furnished to the Cabinet upon request and made available for inspection and copying by Cabinet personnel.

The specific format used for health records is left to the management of the center. It is important, however, that essential information be organized in such a way as to be readily accessible and adequate for the purpose of establishing the current treatment modality and progress of the individual.

Health records maintained on each client receiving services shall contain at least an identification sheet, permission for treatment sheet, the purpose for seeking service, problems, screening information relative to the problem, pertinent medical, psychiatric and social information disposition (result or treatment plan), assigned status, assigned therapist(s) and staff service notes.

The essential parts of the health record include:

(1) INDENTIFICATION

The IDENTIFICATION or INTAKE SHEET shall include: name, social security number, date of intake, home (legal) address, sex, birth date, religion, next of kin or other responsible party and address, health insurance, referral source and address, personal physician and address, the reason the person is seeking help (presenting problem or diagnosis), the name of the informant and any other information needed to meet state and other center requirements.

(2) SCREENING, EVALUATIONS, and DISPOSITION

The extent and type of evaluations obtained at the time of screening are dependent on the problem of the client seeking or being referred for service.

Screening shall include information relative to the client's problem(s) and other personal and health needs. Psychiatric, psychological, psycho-social and other evaluations rendered following screening shall be completed in accordance with accepted professional principles.

Immediately following screening, disposition shall be made relative to:

(a) an assigned status

(b) the case is referred for staffing for further discussion and disposition or
(c) the case is terminated and referred to an outside source for further service or
(d) the case is terminated and further service is not required.

(3) STAFFING and TREATMENT PLAN

There shall be staffing conferences following screening to discuss cases, establish diagnosis or clinical impression, recommend additional evaluations and formulate a comprehensive treatment plan which shall include short term and long range goals as well as treatment modalities. Each client receiving direct treatment under the auspices of a community mental health center shall have an individual plan of care signed by a clinically licensed or certified professional provider of the treatment**,** as stated in Section III, C (2-5) and D(1–7). Subsequent updates and revisions to the plan of treatment will be signed and updated by the clinician providing the mental health service. If a psychiatrist, physician (MD), or an Advanced Registered Nurse Practitioner (ARNP) is involved in providing care to the patient, the psychiatrist, MD or ARNP will also sign the plan of treatment. Other cases shall be discussed at staff conferences or with another professional staff recipient during treatment of individuals for the purpose of reviewing and revising the treatment plan. There shall be evidence of these conferences or consultations in the health records.

The Treatment Plan shall be reviewed at least once a year and the record shall document the review.

(4) HISTORY and EXAMINATIONS

A complete history, including mental status and treatment rendered shall be required on all Medicaid recipients admitted for treatment by the center.

A current hospital discharge summary containing history information is acceptable or if a history is done outside the center and submitted, it shall be acceptable to the psychiatrist in charge based on content.

Staff notes shall be written within one working day of each visit and shall describe the client's symptoms or behavior, reaction to treatment, attitude, the therapist's

intervention, changes in treatment plan, and need for continued treatment.

(5) STAFF NOTES

All staff notes shall be in chronological order, dated, entitled as to service rendered, have a starting and ending time for the services, and be recorded and signed by the staff person rendering the service with title, i.e. MSW, Psych., Prof. Eq., etc. Family collateral, telephone and other significant contacts shall also be recorded in the staff notes.

All staff notes shall be recorded and signed by the staff person rendering the service. Initials, typed or stamped signatures are not acceptable.

For therapeutic rehabilitation services, the staff notes of the person delivering the service may be recorded daily, or if the center prefers, as a weekly summary as long as the attendance worksheets are maintained. The weekly summary staff notes shall include a description of the clients' symptoms or behavior, reaction to treatment, attitude, changes in treatment plan, and need for continued treatment. Also a description of activities and how the activities were used to facilitate psychiatric therapy shall also be included in the staff note. The staff note by a paraprofessional shall be co-signed by the supervising professional providing the service.

Staff notes documenting outpatient services provided by a mental health associate shall be co-signed by the supervising professional. There shall be a monthly supervisory note by the professional reflecting consultation concerning the case and the professional's evaluation of services being provided to the client.

(A) LABORATORY TESTS and EXAMINATIONS

Blood and other laboratory tests and examinations shall be performed in accordance with accepted

medical practice on all individuals receiving medications prescribed or administered by the center.

(B) MEDICATION

All chemotherapy used in treatment shall be recorded in staff notes and on a special medication form for easy reference and follow-up. A copy of the prescription issued shall be filed in the health record.

Chemotherapy shall be under the direction of a licensed psychiatrist, a licensed physician supervised by a psychiatrist, or an ARNP certified in psychiatric-mental health nursing practice who meets the requirements established in 201 KAR 20:057, Section 2(1) and Section 6(1) – (3). Prescriptions concerning medication shall not exceed an order for more than five refills.

(C) DIAGNOSIS or CLINICAL IMPRESSION

Diagnosis or clinical impressions shall be in the terminology of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR™).

Other intercurrent (physical) diagnoses shall be recorded, followed by information as to where treatment is being received and by whom it is being provided.

Diagnoses shall be recorded in the health record within three visits, in order to receive Medicaid payment.

(6) TERMINATION SUMMARY

A termination of summary is required on all clients seen in excess of 3 visits and shall contain a recapitulation of the significant findings and events during treatment, including the final evaluation regarding progress of the client toward goals and objectives set forth in the

treatment plan, final diagnosis of clinical impression, and condition on termination and disposition.

(7) HEALTH RECORD COMPLETION

Active records and those on terminated cases shall be completed promptly.

Evaluations and examinations are to be completed within three (3) working days following visits.

Health records of terminated cases are completed within ten (10) days following termination.

If a case is reopened within ninety (90) days for the same or related problem, reference to the previous case history with an interval note shall suffice.

a. RETENTION OF RECORDS

All health records of terminated clients shall be completed promptly and retained for a period of time determined by the governing authority or in accordance with KRS, which is currently five (5) years.

If a client is transferred or referred to another health care facility for continued care and treatment, a copy of an abstract of his health record shall be forwarded immediately.

In the event of a change in management of a center program, all health records, indexes and registers shall remain the property of the center and be transferred to the new owner.

b. CONFIDENTIALITY OF HEALTH RECORDS

All information contained in the health record is treated as confidential and is disclosed only to authorized persons, authorized Cabinet for Health and Family Services representatives, or authorized representation of the Federal Government.

The provider shall provide to representatives of the Cabinet for Health and Family services requested information to substantiate:

1. staff notes detailing service rendered
2. professional rendering service
3. type of service rendered and any other requested information necessary to determine on an individual client and service basis whether services are reimbursable by Medicaid.

Failure of the community Mental Health Center to provide to Cabinet for Health and Family Services staff requested documentation shall result in denial of payment for those billed services.

G. Application for Participation

A community Mental Health Center, being in compliance with the standards as outlined in Title II of Public Law 88-164, licensed in accordance with 902 KAE 20:091 and meeting the requirements of Medicaid as set forth in 907 KAR 1:044, may submit a Provider Application, MAP-811, to the Department for Medicaid Services. The application and instructions for use may be accessed at the KyHealth Choices web site.

H. Out-of-State Facility

Kentucky Medicaid reimbursement for out patient psychiatric services provided in an out-or-state facility is limited to the following conditions as specified in section 1102 off the social Security Act, Part 431, Paragraph 431.52, (b) Payment for Services:

“A State Plan must provide that the State will furnish Medicaid – to (1) a recipient who is a resident of the State while that recipient is in another State, to the same extent that Medicaid is furnished to residents in the State, when

(a) Medical services are needed because of a medical emergency;

(b) Medical services are needed because the recipient's health would be endangered if he were required to travel to his State of residence;

(c) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; or

(d) It is general practice for recipients in a particular locality to use medical resources in another State; and

(2)A child for whom the State makes adoption assistance or foster care maintenance payments under Title IV-E of the Act."

The out-of-state facility shall be licensed to provide the community mental health center or outpatient psychiatric services by the state in which it is located, and shall participate as a provider of these services in that state's title XIX (Medicaid) Program.

An out-of-state facility shall submit a copy of the negotiated participation agreement with their state's Title XIX Program and a copy of that state's Medicaid reimbursement rates for the covered services, in addition to the items listed in paragraph G. Application for Participation, this section.

I. Termination of Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Health and Family Services determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards

3. Misrepresenting factors concerning a facility's qualifications as a provider

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice shall state:

1. The reasons for the decision
2. The effective date
3. The extent of its applicability to participation in the Medicaid Program
4. The earliest date on which the Cabinet shall accept a request for reinstatement
5. The requirements and procedures for reinstatement; and
6. The appeal rights available to the excluded party.

The provider receiving the notice may request an evidentiary hearing. The request shall be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Health and Family Services. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based
2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision
3. Counsel representing the provider
4. An opportunity to be heard in person, to call witnesses, and in introduce documentary and other demonstrative evidence; and
5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of CHFS.

These procedures apply to any provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon Medicaid. Adverse action taken against a provider under Medicare shall be appealed through Medicare procedures.

IV. COVERED SERVICES

Psychiatric services provided by participating mental health centers shall be covered through the Community Mental Health element of the Medicaid Program when provided in accordance with Program policy and guidelines as stated in this section. All covered services are listed in Appendix II of this manual.

A. Inpatient Services

Inpatient service provided by a community mental health center shall be designed to provide a therapeutic program for persons requiring full-time care. This shall be utilized only when, and for so long as, no other service of the center is appropriate. The service may be provided in a local general hospital affiliated with the community mental health center, as evidenced by a contract which assures that the appropriate patient services are provided.

1. Initial Inpatient Service
   The initial inpatient face-to-face service shall be provided by the center-based psychiatrist before any other inpatient services are payable.

2. Additional Inpatient Services
   Following the initial inpatient service, the psychiatrist may determine that the staff psychologist, psychiatric nurse, psychiatric social worker, licensed professional clinical counselor, licensed professional clinical associate, licensed marriage and family therapist or an equivalent professional may provide therapy for the hospitalized recipient. These services shall be reimbursable when provided under the direction of a plan of care approved by the psychiatrist and recorded in the medical record. Documentation of each service provided shall be recorded, signed and available in the client's center-based record.

   CMHC clients, who are hospitalized for a diagnosis other than a mental illness diagnosis, may continue to receive outpatient services provided as a part of the client's approved plan of treatment. The psychiatrist

does not need to see the client prior to the services being provided.

B. Outpatient Services

1. General Information

Outpatient services may be either on-site, which are defined as the CMHC, leased space and donated space, or off-site which includes the client's home, congregate living facility not otherwise reimbursed by Medicaid, school or day care center, senior citizen's center, and Family Resource and Youth Center.

Outpatient services shall be provided on a regularly scheduled basis, with arrangements made for nonscheduled visits during times of increased stress or crisis. The outpatient service shall be the primary point for diagnosis and evaluation of psychiatric problems and the source of referrals to other services and other agencies. All outpatient services shall be provided in accordance with a plan of treatment.

If outpatient services are provided by a staff recipient other than the eight (8) recognized mental health professionals, the services shall be delivered according to a plan of treatment which has been developed in direct consultation with one (1) of the six (6) principle disciplines. Ongoing consultation shall also be maintained with the supervisory staff recipient throughout the duration of the client's treatment. Staff notes should clearly reflect the input of and supervision by the psychiatrist or supervisory staff recipient as well as their countersignature.

Outpatient services (with the exception of personal care homes) shall be the only services which may be provided by a staff recipient other that the eight (8) designated mental health professionals) psychiatrist, master social worker, psychologist, psychiatric nurse, licensed professional clinical counselor, licensed professional clinical associate, licensed marriage and family therapist and a professional equivalent.

2. Individual Therapy

Individual therapy is defined as therapeutic intervention provided by a qualified mental health center staff for the purpose of reducing or eliminating the presenting problem of

the client. This service may include many different modalities of theory and practice. It shall be provided in a face-to-face, one-on-one encounter between the mental health center staff and the client.

3. Group Therapy
   Group therapy shall be therapeutic intervention provided by qualified mental health center staff to a group of persons. A group consists of no more than twelve (12) persons. It is usually for a limited time period (generally 1 to 1 ½ hours in duration.) In group therapy, clients are involved with one another at a cognitive and emotional level. Group therapy focuses on the emotional and psychological needs of the clients as evidenced in each client's plan of treatment. Group therapy centers around subjects such as building and maintaining healthy relationships, personal goal setting, and the exercise of personal judgment. The subject of each group should be relative to all clients participating in the group therapy. Group therapy is distinct from therapeutic rehabilitation services which offer group activities in a therapeutic environment that focus on the development and restoration of the skills of daily living. .

   Group therapy shall not include physical exercise, recreational, educational, or social activities.

4. Family Therapy
   Family Therapy shall be a therapeutic intervention plan for all recipients of either the client's immediate household or extended family recipients who have close association with the client. The need for family therapy shall be so stated in the client's plan of treatment. Family therapy services shall be for the benefit of the client and shall be billed under that individual client's MAID number.

5. Collateral Services
   Collateral services shall be limited to recipients under the age of twenty-one (21), who are clients of the CMHC.

   Definition:
   Collateral services are face-to-face encounters with parents, legal representative, school personnel or other persons in a position of custodial control or supervision of the client, for

the purpose of providing counseling or consultation on behalf of a client in accordance with an established plan of care.

Persons in a role of supervision may include day care providers, house parents, camp counselor, patient's physician, or a social worker with case management responsibility who is not employed by the CMHC.

The services shall be provided by qualified mental health center staff, (psychologist, professional equivalent, psychiatric nurse, social worker, licensed professional clinical counselor, licensed professional clinical associate, licensed marriage and family therapist and mental health associate) and may include consultation, counseling, assessment, family support on behalf of the child with a focus to accomplish the goals outlined in the plans of treatment. The services may be provided on or off-site. Services delivered to more than one (1) person at the same time shall be billed as if the time were spent with an individual client.

The parent or legal representative in a role of supervision of the child shall give written approval for this service. This written approval shall be kept in the recipient's medical record.

A billable unit of service is the actual time spent face-to-face delivering an actual service. Time spent in traveling to and from an off-site visit shall not be billed.

6. Intensive In-Home Services

Intensive in-home services shall be limited to children, under age twenty-one (21), who are at risk of placement outside the home into a psychiatric hospital or hospital unit, residential treatment facility or foster care. Risk of placement shall also be interpreted to include the child who has been returned to the home from a placement and whose family placement is likely to be unstable if intensive in-home services are not provided.

Intensive in-home services include the provision of therapeutic services, with the goal of preventing out-of-home placement by teaching problem solving skills, behavior strategies, normalization activities, and other treatment modalities as appropriate.

Billable services shall be face-to-face encounters with the child or his family. Generally, intensive in-home services would be expected to be provided for a duration of four (4) to six (6) weeks for an average of three (3) hours per week of face-to-face encounters with the child and family. However, duration and intensity may vary depending on the individual case and may range up to three (3) or even six (6) months, and for more time intensive interventions greater than three (3) hours per week. Family of the child includes those individuals who interact with the child in the household in which the child resides or the family with whom unification is planned.

7. Home Visits

Outpatient services may be provided in the patient's place of residence, as long as the place of residence is other than a facility that is eligible for Medicaid participation. Please note that residence in a public institution may preclude eligibility for Medicaid benefits.

Situations in which home visits may be appropriate would include, but not be limited to the following: 1) as part of a beginning assessment in difficult cases, 2) a family crisis in which immediate intervention is needed, 3) as a means of providing outreach in high risk cases, 4) as a means of providing services to homebound individuals, and 5) as a means of helping the client generalize skills to the home setting.

Examples of situations where home visits may be appropriate "as a means of helping a client generalize skills to the home setting" include:

a. Assisting family recipients and seriously mentally ill clients to defuse stressful situations which occur in the home by assisting them to practice effective communication techniques in that setting.
b. Coaching a mentally ill client to initiate social interactions with others in the home setting. When this becomes stressful and precipitates withdrawal or "inappropriate acting out," intervening with the client to practice relaxation or tension reduction techniques.

c. Intervening with families where domestic violence is a problem to practice fair arguing techniques or to practice face-saving withdrawal from an argument.
d. Coaching family recipients in carrying out new behaviors aimed at helping a school-phobic child attend school for several mornings until the family can manage without outside support.
e. Observing family recipients trying to manage a severely acting out child at a period of the day which is very chaotic for them, (e.g., evening meal time) and intervene in the situation to help them improve their behavior management skills.
f. Helping a parent and child communicate in the environment where problems are most likely to occur.
g. Counseling and supporting persons with severe anxieties who are initially too anxious to learn skills outside their home environment.

8. Emergency Services

The emergency service of a community mental health center shall provide immediate mental health care on a twenty-four (24) hours a day, seven (7) days a week basis. This service may be provided in many methods.

All components of the emergency services shall be coordinated into a unified program, with assurance that patients receiving emergency services can be readily transferred to other services of the center as their needs dictate.

9. Personal Care Home Services

The Community Mental Health Center may request vendor payment for covered services to eligible recipients in personal care homes by a psychiatrist, psychologist, psychiatric nurse, master social worker, licensed professional clinical counselor, licensed professional clinical associate, licensed marriage and family therapist or an equivalent professional, provided the services are in accordance with the plan of treatment. Staff notes shall be recorded for EACH VISIT to EACH RESIDENT of the personal care home, and shall be by the covered professional rendering the service. Resocialization or

remotivation groups shall be covered services if these are mental health services provided under the direction of a plan of treatment, and individual staff notes document the client's psychiatric symptoms, progress and need for continued therapy.

CMHC staff shall also describe the re-socialization or re-motivation group activities and how these group activities facilitate psychiatric therapy. All mental health services, except individual therapies, that are provided in a personal care home shall be covered as personal care home services.

10. Therapeutic Rehabilitation Services for Adults

A therapeutic rehabilitation program of a community mental health center is a goal oriented service for persons with mental illness which provides a therapeutic program for persons who require less than twenty-four (24) hours a day care but more than outpatient counseling. Therapeutic rehabilitation shall be an effective intervention, the purpose of which is to assure that a person with a psychiatric disability possesses those physical, emotional, and intellectual skills to live, learn, and work in his own particular environment.

Services shall be designed for the development, acquisition, enhancement, and maintenance of social, personal adjustment, and daily living skills. The focus of all services shall be on helping clients to develop and maintain a healthy self-esteem. Clients shall be encouraged to retain the fullest possible control of their daily lives, to set their own rehabilitation goals, and to participate fully in decisions affecting their own lives and future.

Medicaid shall make payment for eligible clients in therapeutic rehabilitation programs if specified by a treatment plan approved and signed by the psychiatrist and if the following requirements are met:

a. A psychiatrist shall be present in the therapeutic rehabilitation program on a regularly scheduled basis, at least monthly, and shall assume clinical responsibility for all patients, including the development of the plan of treatment.
b. The program shall have direct supervision by the psychiatrist, psychologist, licensed professional clinical counselor, licensed

marriage and family therapist, psychiatric nurse, master degree social worker or a professional equivalent. This professional shall be present in the therapeutic rehabilitation program to provide direct, ongoing supervision and to serve as a source of guidance for other recipients of the therapeutic team.

11. Therapeutic Rehabilitation Services for Children

Children's therapeutic rehabilitation program shall be a goal-oriented program for children under age twenty-one (21) who have a mental health diagnosis (DSM-IV-TR™), and who require more than intermittent outpatient services. The need for this level of intervention shall be identified by the appropriate mental health center staff and shall be indicated in the child's plan of treatment. Therapeutic rehabilitation shall be an effective daily intervention plan to develop, enhance, and maintain social, personal adjustment, and daily living skills, as well as the child's self-esteem. These services supplement clinical services such as individual, group, and family therapy. The focus of all services shall be to assist the child in developing a healthy self-concept and to develop the ability to function in the community.

The program shall have the direct supervision of a psychiatrist, psychologist, psychiatric nurse, master degree social worker licensed professional clinical counselor, licensed marriage and family therapist, or a professional equivalent. This professional shall be present in the therapeutic rehabilitation program to provide direct, ongoing supervision and to serve as a source of guidance for other recipients of the therapeutic team.

A psychiatrist shall be present in the therapeutic rehabilitation program on a regularly scheduled basis, at least monthly, and shall assume clinical responsibility for all clients, including the development of a plan of treatment. Treatment plans shall be reviewed and updated by staff at least every three (3) months.

A weekly summary note shall be used to document billable services. Staff notes shall be written by the person providing the service and cosigned, when appropriate, by the qualified mental health center staff. The weekly summary note shall reflect the goals and objectives identified in the treatment plan. In addition, it shall include an objective description of the child's attitude, a reaction to treatment, progress, behavior, suggested changes in treatment, and other information as deemed relative to the child's case. A description of the activities and how the activities were used to facilitate psychiatric therapy shall also be included.

Educational services and needs shall NOT be covered by Medicaid. However, it is recognized that children participating in a therapeutic rehabilitation program have specific educational needs; therefore, the mental health professional and educational system work in a collaborative effort.

Children's therapeutic rehabilitation services may be provided twelve (12) months a year. Individual, group, and family therapies and collateral services may be provided in addition to the therapeutic rehabilitation services.

12. Evaluations, Examinations, Testing

These services shall be diagnostic in nature. Psychiatric evaluations and testing shall be performed only by the psychiatrist or an ARNP, certified in psychiatric-mental health nursing practice, who meets the requirements established in 201 KAR 20:057, Section 2(1). Psychological examinations and testing shall be performed by either the psychologist or psychiatrist. These tests shall be a prelude to therapy. Professional evaluation of all tests shall be handled as administrative costs.

13. Physical Examinations

Physical examination of clients of the CMHC shall be provided by either the center-based physician or psychiatrist, or an ARNP, certified in psychiatric-mental health nursing practice, who meets the

requirements established in 201 KAR 20:057, Section 2(1).

14. Services in a Detoxification Setting

The only services covered in a detoxification setting are psychiatric services provided by the center-based psychiatrist, or an ARNP, certified in psychiatric-mental health nursing practice, who meets the requirements established in 201 KAR 20:057, Section 2(1) and Section 6(1) – (3).

15. Chemotherapy Services

The medical evaluation of the effectiveness of psychotropic treatments shall be performed by either the physician or psychiatrist, or an ARNP, certified in psychiatric-mental health nursing practice, who meets the requirements established in 201 KAR 20:057, Section 2(1) and Section 6(1) – (3).

C. Limitations

1. Diagnosis Deferred

Treatment in a CMHC for clients with the above "diagnosis" shall be covered if the services are provided by any of the seven (7) recognized mental health professionals. Recording of the diagnosis in the client's record by the third visit shall be a requisite for Medicaid payment.

2. Speech Disturbance

Medicaid shall reimburse the CMHC for the services of a psychiatrist or psychologist to a client with the diagnosis of a speech disturbance which is symptomatic of a psychiatric problem. Speech therapy shall be considered outside the scope of Program benefits of the discipline providing speech therapy.

3. Services to Persons with Mental Retardation

When the client's diagnosis is mental retardation, the client shall have an additional psychiatric diagnosis substantiating the need for psychiatric treatment. Diagnoses of developmental disorders, i.e., learning disabilities, shall not be acceptable. Services

rendered to persons with mental retardation in need of psychiatric services by a psychiatrist, psychologist, psychiatric nurse, master social worker, licensed professional clinical counselor, licensed professional clinical associate, licensed marriage and family therapist or a professional equivalent shall be covered by Medicaid when rendered in accordance with the psychiatrist's plan of treatment. The staff note shall document the psychiatric treatment rendered.

4. Group Therapy
   Group therapy services shall be limited to groups of twelve (12) or fewer per mental health center staff. Clients shall be limited to a maximum of three (3) hours of group therapy per day.

5. Individual Therapy
   Individual therapy services shall be limited to a maximum of three (3) hours per day.

D. Non-Covered Services

The following services shall NOT be payable by the community mental health element of Medicaid:

1. Speech Therapy
2. Services provided to residents of nursing facilities.
3. Substance abuse services, including institutional or inpatient care services for patients with a diagnosis of substance abuse.
4. Services to the mentally retarded, without documentation of an additional psychiatric diagnosis.
5. Psychiatric or psychological testing for other agencies such as courts or schools, which does not result in the client receiving psychiatric intervention or therapy.
6. Consultation, educational services, or collateral therapy for ages 21 and over

Consultation or third party contracts shall be outside the scope of covered benefits. Covered services require direct patient contact except collateral services for children under age twenty-one (21), when a part of the plan of care.

7. Telephone calls or contacts.
8. Travel time.
9. Field trips and other off-site activities.
10. Recreational, social, and physical exercise activity groups.

These limitations and non-covered services shall be monitored by the Department using a combination of system edits during claims processing and of post-payment reviews and audits. Payment for any services provided outside of the scope of covered benefits shall be refunded to DMS.

V. REIMBURSEMENT

A. In-State Providers

Financial reimbursement for covered community mental health services provided to eligible Medicaid recipients shall be made directly to licensed, participating CMHC's on the basis of a prospective cost reimbursement system in accordance with the policies and principles set forth by the CHFS Community Mental Health-Mental Retardation Reimbursement Manual.

Medicaid reserves the right to question services billed to the Program. The medical review personnel are qualified professional people bound by confidentiality when evaluating documents from a client's record; and all information submitted as documentation for services rendered shall be handled in a confidential manner.

Billed services that are not substantiated or confirmed by staff notes, signatures, or other supporting documentation when requested by Program staff shall be denied for payment on a post-payment basis. This also includes services for which staff notes are requested but not provided by a center. If payment for the unsupported services has been made, a refund shall be requested; or the amount owed shall be withheld from a future payment.

B. Out-of-State Providers

Medicaid may make payment to out-of-state providers under circumstances described in Conditions of Participation, who are appropriately licensed, participate with their State's Title XIX Medicaid Program, and have met Medicaid conditions of participation for CMHC. The payment rate shall be the lower of (1) submitted charges, (2) the facility's rate as set by the State Medicaid agency, or (3) the upper limit in effect for Kentucky providers.

C. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Medicaid. Refund checks shall be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P. O. Box 2108
Frankfort, Kentucky 40602
Attention: Financial Services

Failure to refund a duplicate or inappropriate payment may be interpreted as fraud or abuse, and prosecuted.

D. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program all participating providers shall submit billings for medical services to a third party when the vendor has prior knowledge that a third party may be liable for payment of the services.

In order to identify those clients who may be covered through a variety of health insurance resources, the provider shall inquire if the client meets any of the following conditions:

- If the client is married or working, inquire about possible health insurance through the client or spouse's employer;
- If the client is a minor, ask about insurance the mother, father, or guardian may carry on the client;
- In cases of active or retired military personnel, request information about CHAMPUS/TRICARE coverage and social security number of the policy holder;
- For people over 65 or disabled, seek a Medicare HIC number;
- Ask if the client has health insurance such as a Medicare Supplement policy, cancer, accident, or indemnity policy, group health or individual insurance, etc.

Verify members' eligibility and other health insurance information by accessing the KyHealth Choices web site: http://home.kymmis.com, or by calling (800) 635-2570 as noted on the back of the client's KyHealth Choices Card.

E. Other Third Party Coverage

If the client has third party resources, then the provider shall obtain payment of rejection from the third party before Medicaid can be billed. When payment is received, the provider shall indicate on the claim form in the appropriate field the amount of the third party payment and attach a copy of the explanation of benefits to the claim form. If the third party rejected the claim, a copy of the rejection notice shall be attached to the Medicaid claim.

Exceptions:
*If the other insurance company has not responded within 120 days of the date of filing a claim to the insurance company, submit with the Medicaid claim a copy of the other insurance claim to EDS indicating “NO RESPONSE” on the Medicaid claim form.

EDS
P. O. Box 2107
Frankfort, Kentucky 40602
Attention: TPL Unit

*If proof of denial for the same client for the same or related services from the insurance company is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.
*A letter from the provider indicating that he contacted XYZ insurance company and spoke with an agent to verify that the client was not covered, can also be attached to the Medicaid claim.

If you have any questions, please write to

EDS
P.O. Box 2107
Frankfort, Kentucky 40602
Attention: Third Party Unit

or call (800) 807-1232.

F. Medicare, Title XVIII, Coverage

Title XVIII, Medicare, has first liability for clients who have both Medicare and Medicaid coverage. CMHC claims for services by a physician or psychiatrist to the clients with dual coverage shall be filed with the Medicare fiscal intermediary before being submitted to EDS.

Upon receipt of the Medicare payment, the amount received shall be entered in the appropriate block on the billing form, CMS-1500 (12/90), and submitted to EDS with the Medicare Explanation of Benefits attached.

When the Medicare allowable amount is applied to the client's deductible liability and therefore no payment is received, the Explanation of Medicare Benefits is to be attached to the CMS-1500 (12/90) invoice and submitted to EDS.

G. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider shall pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment shall be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained, such as, the names of attorneys, other involved parties or the client's employer to the claim when submitted to EDS for Medicaid payment.

H. Claims Over Twelve Months Old

Claims with service dates more than twelve (12) months old shall be considered for processing only with appropriate documentation such as one or more of the following: Remittance statements which verify timely filing, Medicare Explanation of Medical Benefits (EOMB's), Medicare Explanation of Benefits (EOB's), and commercial insurances. Without such documentation, claims over twelve (12) months old shall be denied.

VI. USE OF ELECTRONIC SIGNATURE

The use of an electronic signature by a CMHC services provider refers to the act of attaching a signature by electronic means. Electronic signatures shall comply with the requirements outlined in KRS 369.107, 112 and 118(2). A CMHC services provider choosing to utilize electronic signatures shall:

(1) Develop and implement a written security policy which shall be adhered to by all agency personnel
(2) Stipulate which employees have access to the electronic signature
(3) Ensure the electronic signature is password protected.

The center shall maintain an original signature on file for the purpose of authenticating the signer's identity.

The center shall develop an original signed consent form which shall:

(1) Be completed for each individual utilizing an electronic signature;
(2) Attest to the signature's authenticity; and
(3) Include a statement indicating the individual has been notified of their responsibility in allowing the use of electronic signature.

The center must ensure the electronic signature is affixed to the document and ensure the alteration of the electronic signature shall not occur.

APPENDIX I - PROFESSIONAL EQUIVALENT

Medicaid reimbursement can be made for the services provided by individuals determined by the Community Mental Health Center and confirmed by the Department for Medicaid Services to have professional education and experience equivalent to the four principal disciplines.

I. Definition

"Individuals with equivalent professional education" are persons who by virtue of education, professional training and experience in the provision or delivery of direct mental health services of the type reimbursable by Medicaid are shown (to the satisfaction of the Department) to be qualified to provide mental health services.

II. Documentation

A mental health center desiring to secure reimbursement for services provided by an individual with equivalent professional education shall submit the following data to determine whether the individual does have equivalent professional education:

A. The individual's name, address, employer, date of employment, current job title, and a summary of the individual's current duties. The applicant shall be employed by your agency for not less than six months while providing Medicaid covered services.
B. A legible copy of an official transcript of the individual's undergraduate and graduate education upon which the mental health center is relying to establish that the individual has equivalent professional education. To this should be added information regarding the professional licensure or certification status of the individual.
C. A letter of recommendation from the applicant's immediate supervisor.
D. A completed CMHC covered services form. See page 4 of this Appendix. Case Management is not a covered service by the CMHC program and therefore that experience shall not be counted towards professional equivalency.
E. Other information which the mental health center wishes the Department for Medicaid Services to consider when making the determination.

F. Clarifying information requested of the mental health center by the Department for Medicaid Services.

III. Criteria

A. The center shall apply the following criteria to the information obtained and determine whether the individual has equivalent professional education. The center may determine that the individual has equivalent professional education only when the following conditions exist, the individual has the following degree, and has for the specified period of time demonstrated professional competence in the provision of mental health services in a supervised setting:

1. BA, identical field, 3 years full-time equivalent supervised experience;
2. Master's degree, identical field, 6 months full-time equivalent supervised experience;
3. Doctorate degree, identical field.

An identical field shall be defined has a Bachelor's degree in psychology, sociology, social work, or human services as determined by the Professional Equivalency Review Committee. A master's degree or doctoral degree program that provides a pastoral counseling component may be eligible for consideration.

B. When determining whether "the individual has demonstrated professional competence in the provision of mental health services," the center shall consider such factors as: supervisory job evaluations; amount of job responsibility; disciplinary action taken by the mental health center against the individual; and such other matters as may show that the individual has provided mental health services in a competent and professional manner.
Nothing in these criteria shall be construed to negate the specific provisions and limitations contained in 907 KAR 1:044 or 902 KAR 20:091. For example: the individual of equivalent professional education cannot be reimbursed for non-covered services, or services payable only when performed by a psychiatrist or clinical psychologist.

IV. Application for Professional Equivalency Determination

The center shall submit to the Department for Medicaid Services all information on which the decision regarding equivalency has been made, and is requested to summarize the most essential points considered in determining the equivalency status. The Department for Medicaid Services shall provide to the mental health center a confirmation of the decision as to each individual for whom the center has requested status as an “individual with equivalent professional education: without undue delay.” The Department shall specify the beginning date on which the center may begin receiving reimbursement for the individual determined to have equivalent professional education. The beginning date shall be not later than the month of the request for the confirmation of equivalency if the individual met the qualifications in or prior to that month. Change of employment from on e community mental health center to another community mental health center does not necessitate that reconfirmation be granted by the Department for Medicaid Services, only that the Department for Medicaid Services, be provided notification of the change in employment.

If a decision is made that the individual does not have equivalent professional education, the Department shall state clearly its reasons for the decision.

CMHC COVERED SERVICES

OUTPATIENT SERVICE	PERCENT OF TIME EACH SERVICE	SUPERVISED BY_____
Therapeutic Rehabilitation	_____	_____
Individual Therapy	_____	_____
Group Therapy	_____	_____
Family Therapy	_____	_____
Collateral Therapy	_____	_____
Intensive In-Home Services	_____	_____
TOTAL	_____	

SIGNATURE AND TITLE OF PERSON REQUESTING PROFESSIONAL EQUIVALENCY:

_____
Signature

_____
Title

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up postnatal visits within four (4) to six (6) weeks of the delivery date.

DENTAL SERVICES

Coverage shall be limited but includes cleanings, oral examinations, X-rays, fillings, extractions, palliative treatment of oral pain, hospital and emergency calls for members of all ages. Other preventive dental services (i.e. root canal therapy) and comprehensive orthodontics are also available to members under age twenty-one (21).

DURABLE MEDICAL EQUIPMENT

Certain medically-necessary items of durable medical equipment, orthotic and prosthetic devices shall be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotic and prosthetics. Most items require prior authorization.

EARLY PERIODIC, DIAGNOSIS, AND TREATMENT (EPSDT)

Under the EPSDT program, Medicaid-eligible children, from birth through the birth month of their twenty-second birthday may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Examination
- Growth and Development Assessment
- Hearing, Dental, and Vision Screenings
- Lab tests as indicated
- Assessment or Updating of Immunizations

FAMILY PLANNING SERVICES

Comprehensive family planning services shall be available to all eligible Medicaid members of childbearing age and those minors who can be considered sexually active. Those services shall be offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services also shall be available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, shall be available through the Family Planning Services element of the Kentucky Medicaid Program. Follow-up visits and emergency treatments also shall be provided.

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, shall be paid for by the program for eligible members, to the age of twenty-one (21). Follow-up visits, as well as check-up visits, shall be covered through the hearing services element. Certain hearing aid repairs shall also be paid through the program.

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy, and aid services shall be covered when necessary to help the patient remain at home. Medical social worker services shall be covered when provided as part of these services. Home Health coverage also includes disposable medical supplies. Coverage for home health services shall not be limited by age.

HOSPICE

Medicaid benefits include reimbursement for hospice care for Medicaid members who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance shall also be provided to the patient and family in adjustment to the patient's illness and death. A Medicaid member who elects to receive hospice care waives all rights to certain separately available Medicaid services which shall also be included in the hospice care scope of benefits.

HOSPITAL SERVICES

INPATIENT SERVICES

Kentucky Medicaid benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions shall be preauthorization by a Quality Improvement Organization. Certain surgical procedures shall not be covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medically necessity requiring admission to the hospital. Elective and cosmetic procedures shall be outside the scope of program benefits unless medically necessary or indicated. Reimbursement shall be limited to a maximum of fourteen (14) days per admission except for services provided to members under age one (1) in any hospital and members under age six (6) in hospitals designated as disproportionate share hospitals by Kentucky Medicaid.

OUTPATIENT SERVCIES

Benefits of the Program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician, clinic visits, pharmaceuticals covered, emergency room services in emergency situations as determined by a physician, and services of hospital-based emergency room physicians. There shall be no limitations on the number of hospital outpatient visits or covered services available to Medicaid members.

KENTUCKY COMMISSION FOR HANDICAPPED CHILDREN

The commission provides medical, preventive and remedial services to handicapped children under age twenty-one (21). Targeted Case Management Services are also provided. Members of all ages who have hemophilia may also qualify.

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medicaid participating independent laboratories includes procedures for which the laboratory is certified by Medicare.

LONG TERM CARE FACILITY SERVICES

NURSING FACILITY SERVICES

The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Quality Improvement Organization (QIO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.

INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED (ICF/MR/DD)

A. Services provided to members who require intermittent skilled nursing care and continuous personal care supervision. *
B. Services provided to Medicaid members who are mentally retarded or developmentally disabled prior to age twenty-two (22), who because of their mental and physical condition require care and services which are not provided by community resources. **

*Need for the intermediate level of care must be certified by a PRO.

**Need for the ICF/MR/DD level of care must be certified by a QIO.

The Kentucky Medicaid Program shall make payment to intermediate care facilities for the mentally retarded and developmentally disabled for services provided to Medicaid members who are mentally retarded or developmentally disabled prior to age twenty-two (22), who because of their mental and physical condition require care and services which are not provided by community resources.

The need for the ICF/MR/DD level of care shall be certified by the Kentucky Medicaid Quality Improvement Organization (QIO).

MENTAL HOSPITAL SERVICES

Reimbursement is available for inpatient psychiatric services provided to Medicaid members under the age of twenty-one (21) and age sixty-five (65) or older in a psychiatric hospital. There shall be no limit on length of stay; however, the need for inpatient psychiatric hospital services shall be verified through the utilization control mechanism.

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve members of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Therapeutic Rehabilitation
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid members needing psychiatric treatment may receive services from the community mental health centers and possibly avoid hospitalization. There are fourteen (14) major centers, with satellite center available. The Kentucky Medicaid Program also reimburses psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner – Nurse Anesthetist shall be covered by the Kentucky Medicaid Program.

NURSE MIDWIFE SERVICES

Medicaid coverage shall be available for services performed by a participating Advanced Registered Nurse Practitioner – Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up post partum visits within four (4) to six (6) weeks of the delivery date.

NURSE PRACTITIONER

Services by an Advanced Registered Nurse Practitioner shall be payable if the services provided is within the scope of licensure.

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medicaid Outpatient Drug List when required in the treatment of chronic and acute illnesses shall be covered. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical pharmacy professions. A Drug List is available to individual pharmacists and providers upon request and routinely sent to participating pharmacies and nursing facilities.

Certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization be covered for payment through the Drug Preauthorization Program. In addition, nursing facility residents may receive other drugs which may be prior authorized as a group only for nursing facility residents.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms shall be completed prior to coverage of these procedures.

Non-covered services include:

Most injections, supplies, drugs (except anti-neoplastic drugs, selected vaccines and Rhogam), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:
Certain types of office exams, such as comprehensive office visits, shall be limited to one (1) per twelve (12) month period, per patient, per physician.
PODIATRY SERVICES

Selected services provided by licensed podiatrists shall be covered by the Kentucky Medicaid Program. Routine foot care shall be covered only for certain medical conditions where the care requires professional supervision.

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits shall be generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Renal free-standing dialysis center service benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities, located in rural, medically underserved areas. The program emphasized preventive and maintenance health care for people of all ages. The clinics, though physician-directed, shall also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics in the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

EARLY AND PERIODIC AND SCREENING DIAGNOSIS AND TREATMENT (EPSDT) SPECIAL SERVICES

EPSDT considers medically necessary items and services that are not routinely covered under the state plan. These services are for children from birth through the end of their twenty-first birth month. All services shall be prior authorized by the Department for Medicaid Services.

TRANSPORTATION SERVICES

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered shall be preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participation medical transportation provider. Travel to pharmacies shall not be covered.

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for members of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible members under age twenty-one (21).

PREVENTIVE HEALTH SERVICES

Preventive Health Services shall be provided by health department or districts which have written agreements with the Department for Health Services to provided preventive and remedial health care to Medicaid members.

TARGETED CASE MANAGEMENT SERVICES – ADULTS

Case Management services provided to members 18 years of age or older with chronic mental illness who need assistance in obtaining medical, education, social and other support services.

TARGETED CASE MANAGEMENT SERVICES – CHILDREN

Case Management services provided to SED children who need assistance in obtaining medical, educational, social and other services.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Inpatient psychiatric residential treatment facilities services are limited to residents aged six (6) to twenty-one (21). Program benefits are limited to eligible members who require inpatient psychiatric residential treatment facility services on a continuous basis as a result of a severe mental psychiatric illness. There is no limit on length of stay; however, the need for

inpatient psychiatric residential treatment facility services shall be verified through the utilization control mechanism.

KENPAC: The Kentucky Patient Access and Care System, or Ken PAC, is a special program which links the member with a primary physician or clinic for many Medicaid-covered services. Only members who receive assistance based on Aid to Families with Dependent Children (AFCD) or AFDC-related Medical Assistance Only shall be covered under Ken PAC. The member shall choose the physician or clinic. It is especially important for the Ken PAC member to present his or her Medical Assistance Identification Card each time a service is received.

SUPPORTS FOR COMMUNITY LIVING WAIVER FOR THE MENTALLY RETARDED

The Supports for Community Living Waiver Services provides coverage for an array of community based services that shall be an alternative to receiving services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD).

HOME AND COMMUNITY BASED WAIVER SERVICES

The Home and Community Based Waiver Services program provides Medicaid coverage for a broad array of home-and-community-based services for elderly and disabled members. These services shall be available to members who would otherwise require the services in a nursing facility. The services became available statewide effective July 1, 1987. These services shall be arranged for and provided by home health agencies.

SPECIAL HOME-AND-COMMUNITY-BASED SERVICES MODEL WAIVER II PROGRAM

The Model Waiver II Services Program provides up to sixteen (16) hours of private duty nursing services and respiratory therapy services to disabled ventilator dependent Medicaid members who would otherwise require the level of care provided in a hospital-based skilled nursing facility. This program shall be limited to no more than fifty (50) members.